Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Palliative care for the patient with incurable cancer or advanced disease. Part 2: pain and symptom management.

Bibliographic Source(s)

Medical Services Commission. Palliative care for the patient with incurable cancer or advanced disease. Part 2: pain and symptom management. Victoria (BC): British Columbia Medical Services Commission; 2011 Sep 30. 44 p. [7 references]

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 10, 2016 – Olanzapine : The U.S. Food and Drug Administration (FDA) is warning that the antipsychotic medicine olanzapine can cause a rare but serious skin reaction that can progress to affect other parts of the body. FDA is adding a new warning to the drug labels for all olanzapine-containing products that describes this severe condition known as Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS).
- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): The recommendations below are the second in the Medical Services Commission, British Columbia palliative care guidelines series. See the following guidelines for the rest of the series:

- Palliative care for the patient with incurable cancer or advanced disease. Part 1: approach to care
- Palliative care for the patient with incurable cancer or advanced disease. Part 3: grief and bereavement

This part of the series is divided into seven sections, providing recommendations for evidence-based symptom management. The recommendations are algorithm-based to facilitate quick access to the information required.

Pain Management

Pain Assessment (Refer to the "Cancer Pain Management Algorithm" in the original guideline document)

a. Symptom assessment. Use the OPQRSTUV mnemonic to assess pain:

O	Onset	e.g., When did it start? Acute or gradual onset? Pattern since onset?
P	Provoking/palliating	What brings it on? What makes it better or worse (e.g., rest, meds)?
Q	Quality	Identify neuropathic pain (burning, tingling, numb, itchy, etc.)
R	Region/radiation	Primary location(s) of pain, radiation pattern(s)
S	Severity	Use verbal descriptors and/or 1-10 scale
T	Treatment	Current and past treatment; side effects
U	Understanding	Meaning of the pain to the sufferer, "total pain"
V	Values	Goals and expectations of management for this symptom

b. Physical exam: Look for signs of tumor progression, trauma, or neuropathic etiology: hypo- or hyper-esthesia, allodynia (pain from stimuli not normally painful).

Pain Management Strategies (Refer to the "Cancer Pain Management Algorithm" in the original guideline document)

- Continuous pain requires continuous analgesia; prescribe regular dose versus as needed (prn).
- Start with regular short-acting opioids and titrate to effective dose over a few days before switching to slow release opioids.
- Once pain control is achieved, long-acting (q12h oral or q3days transdermal) agents are preferred to regular short-acting oral preparations for better compliance and sleep.
- Always provide appropriate breakthrough doses of opioid medication, ~10% of total daily dose dosed q1h prn.
- Incident pain (e.g., provoked by activity) may require up to 20% of the total daily dose, given prior to the precipitating activity.
- Use appropriate adjuvant analgesics at any step (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], corticosteroids).
- Record patient medications consistently.

Opioid Selection

Issue	Preferred Opioid Medication	Avoid
Difficult constipation	Fentanyl transdermal or methadone[a]	
Renal failure	Fentanyl transdermal or methadone[a]	Morphine[b], codeine, meperidine[c]
Compliance & convenience	Time release formulations (e.g., morphine, hydromorphone, oxycodone)	
Neuropathic pain	Oxycodone or methadone[d] (anecdotal evidence)	
Opioid naive	Low dose morphine, hydromorphone or oxycodone	Fentanyl transdermal patch (risk of delayed absorption and overdose potential), sufentanil
Injection route (e.g.,	Morphine, hydromorphone, (methadone[e]:	Oxycodone (injectable) is not available in Canada

Issue	Preferred Opioid Medication	Avoid
subcutaneous [SC])	second line)	

a. Fentanyl is primarily (75%) cleared as inactive metabolites by the kidney and methadone is cleared hepatically.
b. Morphine is the least preferred in renal failure because of renally cleared active metabolites.
c. Meperidine (Demerol®) should not be used for the treatment of chronic pain.
d. If a patient in your practice is started on methadone by a palliative care physician, in order to renew prescriptions, it is possible to obtain individual patient methadone prescribing authorization through the College of Physicians and Surgeons of British Columbia.
e. Injectable methadone may be obtained through the Health Canada Special Access Program at www.hc-sc.gc.ca/dhp-mps/acces/drugs-drogues/index-eng.php. Consultation with a palliative care physician is suggested prior to initiation.

Opioid Switching ("Rotation")

- Switch to another opioid when inadequate analgesia is obtained despite dose-limiting adverse effects (AEs). This allows for clearance of opioid metabolites and possibly more effective opioid receptor agonist profile from the new drug.
- Switch to an equianalgesic dose of the second opioid, bearing in mind that published ratios are only a guide and that reassessment and dose modification are required.
- When switching because of AEs (e.g., delirium or generalized hyperalgesia), determine the equianalgesic dose and reduce this dose by 25%. Observe closely, allowing for onset of the new and wearing-off of the previous drug.
- Refer to the table "Equianalgesic Conversion for Morphine" in the original guideline document.

Opioid AEs

Switch if not managed symptomatically and AE persists for >1 week.

- Constipation: Stepwise escalation of regular oral stimulant or osmotic laxative on opioid initiation. Consider methylnaltrexone* for refractory cases. Refer to "Constipation Management Algorithm" in the original guideline document.
- Nausea: Resolves after ~1 week. Consider metoclopramide* first line; avoid dimenhydrinate (Gravol®).
- Sedation: Stimulants may be helpful if sedation persists (e.g., methylphenidate, dextroamphetamine, or modafinil).
- Myoclonus: May respond to benzodiazepines but may be a sign of opioid toxicity requiring hydration, opioid dose reduction or rotation.
- Delirium: Assess for other causes (e.g., hypercalcemia, urinary tract infection [UTI]).
- Pruritus, sweating: Try opioid rotation.

*Cancer, gastrointestinal (GI) malignancy, GI ulcer, Ogilvie's syndrome and concomitant use of certain medications (e.g., NSAIDs, steroids, and bevacizumab) may increase the risk of GI perforation in patients receiving methylnaltrexone. (Health Canada MedEffect Notice: www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/medeff/advisories-avis/prof/2010/relistor_hpc-cps-eng.pdf)

Adjuvant Analgesics

- Select based on type of pain and AE profile. Optimize dosing of one drug before trying another. Discontinue adjuvant drug if ineffective.

Severe Opioid-Resistant Cancer Pain

- Consult a palliative care specialist for advice.

See the table "Medications Used in Palliative Care for Pain Management" in the original guideline document for a list of pain medications by generic and trade names, available dosage forms, standard adult doses, drug plan coverage, and approximate costs of a 30-day supply.

Dyspnea Management (Refer to the "Dyspnea Management Algorithm" in the original guideline document)

Dyspnea Assessment

- Ask the patient to describe dyspnea severity using a 1-10 scale.
- Identify underlying cause(s) and treat as appropriate.
- History and physical exam lead to accurate diagnosis in two-thirds of cases.
- Investigations: complete blood count with differential (CBC/diff), electrolytes, creatinine, oximetry +/- arterial blood gases (ABGs) and pulmonary function, electrocardiogram (ECG), brain natriuretic peptide (BNP) when indicated.
- Imaging: Chest X-ray and computed tomography (CT) scan chest when indicated.

Dyspnea Management Strategies

- Proven therapy includes opioids for relief of dyspnea. Oxygen is only beneficial for relief of hypoxemia.
- Adequate control of dyspnea relieves suffering and improves a patient's quality of life.
- Treat reversible causes where possible and desirable, according to goals of care.
- Always utilize non-pharmacological treatment: education and comfort measures.
- Pharmacological treatment: Opioids, +/- benzodiazepines or neuroleptics, +/- steroids.

Drug	Comments
Opioids (drugs of first choice)	• If opioid naïve, start with morphine 2.5-5 mg by mouth (PO) (subcutaneous [SC] dose is half the PO dose) q4h or equianalgesic dose of hydromorphone or oxycodone. • Breakthrough should be half of the q4h dose ordered q1h prn. • If opioid tolerant, increase current dose by 25% to 50%. • When initiating, start an antiemetic (metoclopramide) and bowel protocol. • Therapeutic doses used to treat dyspnea do not decrease oxygen saturation or cause differences in respiratory rate or CO_2 levels. • Nebulized forms have NOT been shown to be superior to oral opioids and are not recommended.
Benzodiazepines	• Prescribe prn for anxiety and respiratory "panic attacks". • Lorazepam 0.5-2 mg sublingual (SL) q2-4h prn. • Consider SC midazolam in rare cases
Neuroleptics	• Methotrimeprazine 2.5-5 mg PO/SC q8h, then titrate to effect.
Corticosteroids	• Dexamethasone 8-24 mg PO/SC/intravenous (IV) every morning (qam) depending on severity and cause of dyspnea. • Particularly for bronchial obstruction, lymphangitic carcinomatosis, and superior vena cava (SVC) syndrome; also for bronchospasm, radiation pneumonitis and idiopathic interstitial pulmonary fibrosis.
Supplemental O_2	• Indicated only for hypoxia (insufficient evidence of benefit otherwise).

See the table "Medications Used in Palliative Care for Dyspnea and Respiratory Secretions" in the original guideline document for a list of pain medications by generic and trade names, available dosage forms, standard adult doses, drug plan coverage, and approximate costs of a 30-day supply.

Nausea and Vomiting (N&V) Management (Refer to the "Nausea and Vomiting Management Algorithm" in the original guideline document)

Assessment

- Common, but can be controlled with antiemetics.
- Identify and discontinue medications that may be the cause.
- Further assessment may include lab tests and imaging to investigate (e.g., GI tract disturbance, electrolyte/calcium imbalance, intracranial disease, and sepsis).
- Good symptom control may require rehydration which can be carried out in the home, hospice, or residential care facility using hypodermoclysis, a simple, safe and effective technique that avoids venous access (refer to the "Hypodermoclysis Protocol" in the original guideline document).

Management Strategies

- Non-pharmacological: modifications to diet (e.g., small bland meals) and environment (e.g., control smells and noise), relaxation and good

oral hygiene, acupressure (for chemotherapy-induced acute nausea but not for delayed symptoms).

- Pharmacological: match treatment to cause (e.g., if opioid-induced, metoclopramide [sometimes IV or SC initially] and domperidone are most effective). Most drugs are covered by the British Columbia (BC) Palliative Care Drug Plan except olanzapine and ondansetron (see the table "Medications Used in Palliative Care for Nausea and Vomiting" in the original guideline document for a list of pain medications by generic and trade names, available dosage forms, standard adult doses, drug plan coverage, and approximate costs of a 30-day supply).
- Consider pre-emptive use of anti-nauseates in opioid-naive patients.

Constipation Management (Refer to the "Constipation Management Algorithm" in the original guideline document)

Constipation Assessment

- Understand the patient's bowel habit, both current and when previously well (e.g., frequency of bowel movements [BMs], stool size and consistency, ease of evacuation).
- Goal is to restore a patient's normal BM frequency, consistency, and ease of passage.
- For lower performance status patients (e.g., reduced food intake and activity), lower BM frequency is acceptable as long as there is no associated discomfort.

Constipation Management Strategies

- There are many etiologies (e.g., reduced food/fluid/mobility and AEs of medications).
- Avoid rectal interventions (enemas, suppositories, manual evacuation) except in crisis management. Contraindicated when there is potential for serious infection (neutropenia) or bleeding (thrombocytopenia), or when there is rectal/anal disease.
- Exclude impaction when a patient presents already constipated. Abdominal X-ray can be useful when physical examination is inconclusive.
- When risk factors are ongoing, as they are in most cancer patients, suggest laxatives regularly versus prn. Adjust dose individually. Laxatives are most effective when taken via escalating dose according to response, termed "bowel protocol".
- Sennosides (e.g., Senokot®) are the first choice of laxative for prevention and treatment. Patients with irritable bowel syndrome may experience painful cramps with stimulant laxatives and often prefer osmotic laxatives such as lactulose or polyethylene glycol (PEG). There is weak evidence that lactulose and sennosides are equally effective; however lactulose can taste unpleasant and also cause bloating.
- If rectal measures are required, generally a stimulant suppository is tried first, then an enema as the next option.
- BC Palliative Care Drug Plan covers laxatives written on a prescription for eligible patients.
- For patients with opioid-induced constipation, after a trial of first-line recommended stimulant laxatives and osmotic laxatives, methylnaltrexone may be helpful. Cancer, GI malignancy, GI ulcer, Ogilvie's syndrome and concomitant use of certain medications (e.g., NSAIDs, steroids and bevacizumab) may increase the risk of GI perforation in patients receiving methylnaltrexone. (Health Canada MedEffect Notice)
- Patient handouts on constipation and bowel protocol are available from the BC Cancer Agency Web site .

See the table "Medications Used in Palliative Care for Constipation" in the original guideline document for a list of pain medications by generic and trade names, available dosage forms, standard adult doses, drug plan coverage, and approximate costs of a 30-day supply.

Delirium Management (Refer to the "Delirium Management Algorithm" in the original guideline document)

Delirium Assessment

- May be hypoactive, hyperactive or mixed.
- Look for underlying reversible cause (refer to the Fraser Health Authority guideline Hospice Palliative Care Symptom Guidelines - Delirium/Restlessness).
- Ascertain stage of illness and whether delirium is likely to be reversible or terminal and irreversible.
- Review advanced care plan and discuss goals of care with substitute decision maker.
- Refer patient/family to Home and Community Care (see also the section "Resources" in the original guideline document) or timely access to caregiver support and access to respite and/or hospice care.

Delirium Management Strategies

- Treat reversible causes if consistent with goals of care.
- Avoid initiating benzodiazepines for first line treatment.
- Refer to "Delirium Management Algorithm" in the original guideline document.
- Avoid use of antipsychotics in patients diagnosed with Parkinson's disease or Lewy Body dementia.

See the table "Medications Used in Palliative Care for Delirium and Terminal Agitation" in the original guideline document for a list of pain medications by generic and trade names, available dosage forms, standard adult doses, drug plan coverage, and approximate costs of a 30-day supply.

Fatigue and Weakness Management (Refer to the "Fatigue and Weakness Management Algorithm" in the original guideline document)

Fatigue Assessment

- Assess whether symptom is fatigue or weakness (generalized or localized).
- Distinguish fatigue from depression.
- Look for reversible causes of fatigue or weakness (refer to the Fraser Health Authority guideline Hospice Palliative Care Symptom Guidelines, Fatigue).

Fatigue Management Strategies

- After treating reversible causes and providing non-pharmacological treatment recommendations, consider pharmacological treatment (refer to the table "Medications Used in Palliative Care for Fatigue" in the original guideline document), if consistent with patient's goals of care.
- Refer to the "Fatigue and Weakness Management Algorithm" in the original guideline document.

Depression Management (Refer to the "Depression Management Algorithm" in the original guideline document)

Assessment

- Depression occurs in 13% to 26% of patients with terminal illness can amplify pain and other symptoms, and is often recognized too late in a patient's life.
- Patients are at high risk of suicide and have an increased desire for hastened death.
- A useful depression screening question is, "Have you been depressed most of the time for the past two weeks?"
- A diagnosis of depression in the terminally ill may be made when at least two weeks of depressed mood is accompanied by symptoms of hopelessness, helplessness, worthlessness, guilt, lack of reactivity, or suicidal ideation.
- Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV) criteria for depression are not very helpful because vegetative symptoms like anorexia, weight loss, fatigue, insomnia, and impaired concentration may accompany end stage progressive illness.
- Risk factors include: personal or family history of depression, social isolation, concurrent illnesses (e.g., chronic obstructive pulmonary disease [COPD], congestive heart failure [CHF]), alcohol or substance abuse, poorly controlled pain, advanced stage of illness, certain cancers (head and neck, pancreas, primary or metastatic brain cancers), chemotherapy agents (vincristine, vinblastine, asparagines, intrathecal methotrexate, interferon, interleukin), corticosteroids (especially after withdrawal), abrupt onset of menopause (e.g., withdrawal of hormone replacement therapy, use of tamoxifen).

Management Strategies

- Non-pharmacological treatments are the mainstay of treatment for the symptom of depression without a diagnosis of primary affective disorder.
- Treatment of pain and other reversible physical symptoms should occur before initiating antidepressant medication.
- If a diagnosis of primary affective disorder is uncertain in a depressed patient, consider psychiatric referral and a trial of antidepressant medication (refer to the table "Medications Used in Palliative Care for Depression" in the original guideline document). Consider drug interactions, adverse side effect profiles, and beneficial side effects when choosing an antidepressant.
- In the terminally ill, start with half the usual recommended starting dose of antidepressant.
- First line therapy is with a selective serotonin reuptake inhibitor (SSRI) or selective serotonin norepinephrine reuptake inhibitor (SSNRI) or noradrenergic and specific serotonergic antidepressant (NaSSA).
- Tricyclic antidepressants (especially nortriptyline and desipramine) can be considered due to their co-analgesic benefit for neuropathic pain (refer to the table "Medications Used in Palliative Care for Depression" in the original guideline document). Avoid with constipation, urinary retention, dry mouth, orthostatic hypotension, or cardiac conduction delays.
- When anticipated survival time is short, consider psychostimulants due to their more immediate onset of effect, but avoid them in the presence of agitation, confusion, insomnia, anxiety, paranoia, or cardiac comorbidity.
- If life expectancy is 1-3 months, start a psychostimulant and an antidepressant together and then withdraw the stimulant while titrating the antidepressant upwards.

Clinical Algorithm(s)

The following clinical algorithms are provided in the original guideline document:

- Cancer Pain Management Algorithm
- Dyspnea Management Algorithm
- Nausea and Vomiting Management Algorithm
- Constipation Management Algorithm
- Delirium Management Algorithm
- Fatigue and Weakness Management Algorithm
- Depression Management Algorithm

Scope

Disease/Condition(s)

Incurable cancer or advanced neoplasia associated with any of the following:

- Pain
- Dyspnea
- Nausea and vomiting
- Constipation
- Delirium
- Fatigue and weakness
- Depression

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Cardiology

Critical Care

Emergency Medicine

Family Practice

Gastroenterology

Geriatrics

Internal Medicine

Nursing

Oncology

Psychiatry

Psychology

Pulmonary Medicine

Radiation Oncology

Surgery

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Emergency Medical Technicians/Paramedics

Health Care Providers

Hospitals

Nurses

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Respiratory Care Practitioners

Social Workers

Guideline Objective(s)

To present strategies for the assessment and management of cancer pain and symptoms associated with advanced disease

Target Population

Adult patients ≥19 years of age with incurable or advanced cancer who experience pain, dyspnea, nausea and vomiting, constipation, delirium, fatigue and weakness, or depression

Interventions and Practices Considered

Assessment/Diagnosis

1. Symptom assessment, including underlying causes and risk factors
2. Assessment of side effects of pain therapy
3. History and physical examination (PE)
4. Investigations: complete blood count with differential (CBC/diff), electrolytes, creatinine, oximetry +/- arterial blood gases (ABGs) and pulmonary function, electrocardiogram (ECG), brain natriuretic peptide (BNP) when indicated

5. X-ray and computed tomography when indicated
6. Comparison of constipation to pre-illness bowel habits
7. Review of advanced care plan for delirium
8. Discussion of treatment goals with substitute decision maker
9. Referral of patient/family to Home and Community Care office or timely access to caregiver support and access to respite and/or hospice care
10. Distinguishing fatigue from depression
11. Investigation of reversible causes of fatigue or weakness
12. Direct questioning for depression

Management/Treatment

1. Pharmacological treatment
2. Opioid rotation
3. Specialist referral for opioid-resistant pain
4. Consistent recording of pain medications
5. Treatment of underlying causes of symptoms
6. Non-pharmacological interventions
7. Oxygen for hypoxemia
8. Discontinuation of medications that cause nausea and vomiting
9. Control of nausea and vomiting with hypodermoclysis
10. Rectal intervention for constipation only in crisis management (if not contraindicated)
    - Stimulant suppository first
    - Enema second if needed
11. Laxatives taken regularly and adjusted using a "bowel protocol"
    - Sennosides as first-choice laxative
    - Osmotic laxatives for patients with sennoside side effects
12. Methylnaltrexone for patients for whom sennoside and osmotic laxatives are ineffective
13. Provision of patient handouts for constipation
14. Treating reversible causes of symptoms
15. Psychiatric referral and a trial of antidepressant medication

Major Outcomes Considered

- Validity and predictive capacity of assessment scales
- Quality of life
- Time to reduction in symptom
- Incidence of adverse effects or complications from treatment or intervention
- Frequency of need for combination therapy
- Frequency of specialist referral
- Incidence of breakthrough of symptoms
- Effectiveness of non-pharmacological versus pharmacological interventions

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Evidence was obtained through a systematic review of peer-reviewed literature (up to December 2010) using the databases MEDLINE, PubMed,

EBSCO, Ovid, and the Cochrane Collaboration's Database for Systematic Reviews. Clinical practice guidelines from other jurisdictions for palliative care/end of life care and the following: pain management, dyspnea, nausea and vomiting, constipation, delirium, fatigue and weakness and depression were also reviewed (up to December 2010).

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Not stated

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This is an evidence based clinical guideline for general practitioners including consensus statements when evidence is not available. It is based on scientific evidence current as of the Effective Date.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

This is an evidence based clinical guideline for general practitioners with consensus statements when evidence is not available. The type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate assessment and management of pain, dyspnea, nausea and vomiting, constipation, delirium, fatigue and weakness, and depression in patients with incurable cancer or advanced disease

Potential Harms

- Adverse effects of pharmacotherapy
- Drug interactions
- Risk of delayed absorption and overdose potential with fentanyl transdermal patch

Contraindications

Contraindications

- Avoid rectal interventions (enemas, suppositories, manual evacuation) except in crisis management. They are contraindicated when there is potential for serious infection (neutropenia) or bleeding (thrombocytopenia), or when there is rectal/anal disease.
- Phosphate enemas are contraindicated in patients with renal failure.
- Meperidine (Demerol®) should not be used for the treatment of chronic pain.
- Avoid use of antipsychotics in patients diagnosed with Parkinson's disease or Lewy Body dementia.
- Avoid tricyclic antidepressants with constipation, urinary retention, dry mouth, orthostatic hypotension, or cardiac conduction delays.
- Avoid psychostimulants in the presence of agitation, confusion, insomnia, anxiety, paranoia, or cardiac comorbidity.

Qualifying Statements

Qualifying Statements

The Clinical Practice Guidelines (the "Guidelines") have been developed by the Guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission (MSC). The Guidelines are intended to give an understanding of a clinical problem and outline one or more preferred approaches to the investigation and management of the problem. The Guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problems. The MSC cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a health care professional.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Clinical Algorithm

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Medical Services Commission. Palliative care for the patient with incurable cancer or advanced disease. Part 2: pain and symptom management. Victoria (BC): British Columbia Medical Services Commission; 2011 Sep 30. 44 p. [7 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011 Sep 30

Guideline Developer(s)

Family Practice Oncology Network - Professional Association

Medical Services Commission, British Columbia - State/Local Government Agency [Non-U.S.]

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Guideline Committee

Guidelines and Protocols Advisory Committee

Composition of Group That Authored the Guideline

Not stated

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the British Columbia Ministry of Health Web site .

Availability of Companion Documents

None available

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on January 31, 2013. The information was verified by the guideline developer on March 20, 2013. This summary was updated by ECRI Institute on April 7, 2014 following the U.S. Food and Drug Administration advisory on Methylphenidate ADHD Medications. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI Institute on May 24, 2016 following the U.S. Food and Drug Administration advisory on Olanzapine. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

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